[4120-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-8084-N]

RIN 0938-AV12

Medicare Program; CY 2024 Part A Premiums for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the monthly premium for uninsured enrollees under the Medicare Hospital Insurance (Part A) program in calendar year 2024. This premium is paid by enrollees aged 65 and over who are not otherwise eligible for benefits under Part A (hereafter known as the "uninsured aged") and by certain individuals with disabilities who have exhausted other entitlement. The monthly Part A premium for the 12 months beginning January 1, 2024 for these individuals will be $505. The premium for certain other individuals as described in this notice will be $278.

DATES: The premium announced in this notice is effective on January 1, 2024.

FOR FURTHER INFORMATION CONTACT: Yaminee Thaker, (410) 786-7921.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in the Medicare Hospital Insurance (Part A) program, subject to payment of a monthly premium, of certain persons aged 65 and older who are uninsured under the Old-Age, Survivors, and Disability Insurance (OASDI) program or the Railroad Retirement Act and do not otherwise meet the requirements for entitlement to Part A. These "uninsured aged" individuals are uninsured under the OASDI program or the Railroad Retirement Act because they do not have

40 quarters of coverage under Title II of the Act (or are/were not married to someone who did). (Persons insured under the OASDI program or the Railroad Retirement Act and certain others do not have to pay premiums for Part A.)

Section 1818A of the Act provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium, for certain individuals with disabilities who have exhausted other entitlement. These are individuals who were entitled to coverage due to a disabling impairment under section 226(b) of the Act but who are no longer entitled to disability benefits and premium-free Part A coverage because they have gone back to work and their earnings exceed the statutorily defined "substantial gainful activity" amount (section 223(d)(4) of the Act).

Section 1818A(d)(2) of the Act specifies that the provisions relating to premiums for the aged, under section 1818(d) through section 1818(f), will also apply to certain individuals with disabilities, as described above.

Section 1818(d)(1) of the Act requires us to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services incurred in the upcoming calendar year (CY) (including the associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Part A. We must then determine the monthly actuarial rate for the following year (the per capita amount estimated above divided by 12) and publish the dollar amount for the monthly premium in the succeeding CY. If the premium is not a multiple of $1, it is rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not of $1, it is rounded to the next highest $1).

Section 13508 of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103-66) amended section 1818(d) of the Act to provide for a reduction in the premium amount for certain voluntary enrollees (sections 1818 and 1818A). The reduction applies to an individual who is eligible to buy into the Part A program and who, as of the last day of the previous month:

- Had at least 30 quarters of coverage under Title II of the Act;

- Was married, and had been married for the previous 1-year period, to a person who had at least 30 quarters of coverage;

- Had been married to a person for at least 1 year at the time of the person's death if, at the time of death, the person had at least 30 quarters of coverage; or

- Is divorced from a person who at the time of divorce had at least 30 quarters of coverage if the marriage lasted at least 10 years.

Section 1818(d)(4)(A) of the Act specifies that the premium that these individuals will pay for CY 2024 will be equal to the premium for uninsured aged enrollees reduced by 45 percent.

Section 1818(g) of the Act requires the Secretary of Health and Human Services (the Secretary), at the request of a state, to enter into a Medicare Part A buy-in agreement with the state to pay Part A premiums for Qualified Medicare Beneficiaries (QMBs).[1] Under the QMB eligibility group, state Medicaid agencies must pay the Part A premium for those not eligible for premium-free Part A, if those individuals meet all of the eligibility requirements for the QMB eligibility group under the state's Medicaid state plan. (Entering into a Part A buy-in agreement would permit states to avoid any Part A late enrollment penalties that individuals may owe and would allow states to enroll persons in Part A at any time of the year, without regard to Medicare enrollment periods.) Other individuals may be eligible for the Qualified Disabled and Working Individuals (QDWIs) eligibility group, through which state Medicaid programs provide coverage for the Part A premiums for individuals who are eligible to enroll in Part A by virtue of section 1818A of the Act and meet certain financial eligibility criteria.

II. Monthly Premium Amount for CY 2024

The monthly premium for the uninsured aged and certain individuals with disabilities

[1] Effective on January 1, 2023, the regulatory definition of qualified Medicare beneficiaries at 42 CFR 435.123 has been expanded to include additional individuals. These individuals are only entitled to limited Medicare coverage under Part B for immunosuppressive drugs. Because the new individuals are not entitled to Part A, the expansion of the QMB definition does not change the analysis in this notice.

who have exhausted other entitlement, for the 12 months beginning January 1, 2024, is $505. The monthly premium for the individuals who are eligible under section 1818(d)(4)(B) of the Act, and who are therefore subject to the 45-percent reduction in the monthly premium, is $278.

III. Monthly Premium Rate Calculation

As discussed in section I of this notice, the monthly Medicare Part A premium is equal to the estimated monthly actuarial rate for CY 2024 rounded to the nearest multiple of $1 and equals one-twelfth of the average per capita amount, which is determined by projecting the number of Part A enrollees aged 65 years and over, as well as the benefits and administrative costs that will be incurred on their behalf.

The steps involved in projecting these future costs to the Federal Hospital Insurance Trust Fund are as follows:

- Establishing the present cost of services furnished to beneficiaries, by type of service, to serve as a projection base;
- Projecting increases in payment amounts for each of the service types; and
- Projecting increases in administrative costs.

We base our projections for CY 2024 on (1) current historical data and (2) projection assumptions derived from current law and the President's Fiscal Year 2024 Budget.

For CY 2024, we estimate that 59,121,430 people aged 65 years and over will be entitled to (enrolled in) benefits (without premium payment) and that they will incur about $358,251 billion in benefits and related administrative costs. Thus, the estimated monthly average per capita amount is $504.97, and the monthly premium is $505. Subsequently, the full monthly premium reduced by 45 percent is $278.

IV. Costs to Beneficiaries

The CY 2024 premium of $505 is approximately 0.2 percent lower than the CY 2023 premium of $506. We estimate that approximately 729,000 enrollees will voluntarily enroll in Medicare Part A by paying the full premium and that over 90 percent of these individuals will

have their Part A premium paid for by states, since they are entitled to Part A and enrolled in the QMB program eligibility group. Furthermore, the CY 2024 reduced premium is the same as for CY 2023, at $278, and we estimate that an additional 94,000 enrollees will pay this premium. Therefore, for enrollees paying these premiums in CY 2024, we estimate that the total aggregate savings, compared with the amount that they paid in CY 2023, will be about $9 million.

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment prior to a rule taking effect in accordance with section 1871 of the Act and section 553(b) of the Administrative Procedure Act (APA). Section 1871(a)(2) of the Act provides that no rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under Medicare shall take effect unless it is promulgated through notice and comment rulemaking. Unless there is a statutory exception, section 1871(b)(1) of the Act generally requires the Secretary to provide for notice of a proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment before establishing or changing a substantive legal standard regarding the matters enumerated by the statute. Similarly, under 5 U.S.C. 553(b) of the APA, the agency is required to publish a notice of proposed rulemaking in the **Federal Register** before a substantive rule takes effect. Section 553(d) of the APA and section 1871(e)(1)(B)(i) of the Act usually require a 30-day delay in effective date after issuance or publication of a rule, subject to exceptions. Sections 553(b)(B) and 553(d)(3) of the APA provide for exceptions from the advance notice and comment requirement and the delay in effective date requirements. Sections 1871(b)(2)(C) and 1871(e)(1)(B)(ii) of the Act also provide exceptions from the notice and 60-day comment period and the 30-day delay in effective date. Section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act expressly authorize an agency to dispense with notice and comment rulemaking for

good cause if the agency makes a finding that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest.

The annual Medicare Part A premium announcement set forth in this notice does not establish or change a substantive legal standard regarding the matters enumerated by the statute or constitute a substantive rule that would be subject to the notice requirements in section 553(b) of the APA. However, to the extent that an opportunity for public notice and comment could be construed as required for this notice, we find good cause to waive this requirement.

Section 1818(d) of the Act requires the Secretary, during September of each year, to determine and publish the amount to be paid, on an average per capita basis, from the Federal Hospital Insurance Trust Fund for services incurred in the impending CY (including the associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Part A. Further, the statute requires that the agency determine the applicable premium amount for each CY in accordance with the statutory formula. In this notice, we are simply notifying the public of the changes to the Part A premiums for CY 2024. We have calculated the Part A premiums as directed by the statute, which establishes both when the premium amounts must be published and what information must be factored by the Secretary into these amounts; we do not have any discretion in that regard. We find notice and comment procedures to be unnecessary for this notice, and we find good cause to waive such procedures under section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act, if such procedures may be construed to be required at all. Through this notice, we are simply notifying the public of the updates to the Part A premiums, in accordance with the statute, for CY 2024. As such, we also note that even if notice and comment procedures were required for this notice, for the reasons stated above we would find good cause to waive the delay in effective date of the notice, as additional delay would be contrary to the public interest under section 1871(e)(1)(B)(ii) of the Act. Publication of this notice is consistent with section 1818(d) of the Act, and we believe that any potential delay in the effective date of the notice, if such delay were required at all, could

cause unnecessary confusion for both the agency and Medicare beneficiaries.

VI. Collection of Information Requirements

This document does not impose information collection requirements—that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

VII. Regulatory Impact Analysis

Although this notice does not constitute a substantive rule, we nevertheless prepared this Regulatory Impact Analysis section in the interest of ensuring that the impacts of this notice are fully understood.

A. Statement of Need

This notice announces the CY 2024 Medicare Part A premiums for the uninsured aged and for certain disabled individuals who have exhausted other entitlement, as required by sections 1818 and 1818A of the Act. It also responds to section 1818(d) of the Act, which requires the Secretary to provide for publication of these amounts in the **Federal Register** during the September that precedes the start of each CY. As this statutory provision prescribes a detailed methodology for calculating these amounts, we do not have the discretion to adopt an alternative approach on these issues.

B. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993); Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011); Executive Order 14094 entitled "Modernizing Regulatory Review" (April 6, 2023); the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354); section 1102(b) of the Social Security Act; section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4); Executive Order 13132 on Federalism (August 4, 1999); and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health, and safety effects; distributive impacts; and equity). Executive Order 14094, "Modernizing Regulatory Review," amends section 3(f)(1) of Executive Order 12866 (Regulatory Planning and Review). The amended section 3(f) of Executive Order 12866 defines a "significant regulatory action" as an action that is likely to result in a rule (1) having an annual effect on the economy of $200 million or more in any 1 year (adjusted every 3 years by the Administrator of the Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product) or adversely affecting in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or tribal governments or communities; (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising legal or policy issues, for which centralized review would meaningfully further the President's priorities or the principles set forth in this Executive order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action/s and/or with significant effects as per section 3(f)(1) of Executive Order 12866 ($200 million or more in any 1 year). Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined that this rulemaking is not significant and not major under Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act).

As stated in section IV of this notice, we estimate that the overall effect of the changes in the Medicare Part A premium will be a savings to voluntary enrollees (sections 1818 and 1818A of the Act) of about $9 million.

C. Accounting Statement and Table

As required by OMB Circular A-4 (available at https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf), in the Table below we have prepared an accounting statement showing the total aggregate savings to enrollees paying premiums in CY 2024, compared with the amount that they paid in CY 2023. The amount of savings will be about $9 million. As stated in section IV of this notice, the CY 2024 premium of $505 is approximately 0.2 percent lower than the CY 2023 premium of $506. We estimate that approximately 729,000 enrollees will voluntarily enroll in Medicare Part A by paying the full premium and that over 90 percent of these individuals will have their Part A premium paid for by states, since they are enrolled in the QMB eligibility group. Furthermore, the CY 2024 reduced premium of $278 is the same as for CY 2023.

TABLE: Estimated Transfers for CY 2024 Medicare Part A Premiums	
Category	**Transfers**
Annualized Monetized Transfers	−$9 million
From Whom to Whom	Beneficiaries to Federal Government

D. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) requires agencies to analyze options for regulatory relief of small entities if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration's definition of a small business (having revenues of less than $9.0 million to $47 million in any 1 year). Individuals and states are not included in the definition of a small entity. This annual notice announces the Medicare Part A premiums for CY 2024 and will have an impact on certain Medicare beneficiaries. As a result, we are not preparing an analysis for the RFA because the Secretary has certified that this notice will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This annual notice announces the Medicare Part A premiums for CY 2024 and will have an impact on certain Medicare beneficiaries. As a result, we are not preparing an analysis for section 1102(b) of the Act because the Secretary has certified that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

E. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2023, that threshold is approximately $177 million. This notice would not impose a mandate that will result in expenditures by state, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $177 million in any 1 year.

F. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This notice will not have a substantial direct effect on state or local governments, preempt state law, or otherwise have Federalism implications.

G. Congressional Review

This final regulation is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.) and has been transmitted to the Congress and the Comptroller General for review.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on October 11, 2023.

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Xavier Becerra,

Secretary,

Department of Health and Human Services.

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